ASSEMBLY BILL No. 175

Introduced by Assembly Member Cohn

January 23, 2003

An act to amend Section 1375.7 of the Health and Safety Code, relating to health care service plans.

LEGISLATIVE COUNSEL'S DIGEST

AB 175, as introduced, Cohn. Health care service plans: provider contracts.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Under existing law, a violation of the act's provisions is a crime. The act prohibits certain terms in a contract between a plan and a health care provider that are designated the Health Care Providers' Bill of Rights.

This bill would add a provision to the Health Care Providers' Bill of Rights that prohibits a contract term requiring a provider to furnish services to a person who is not enrolled directly with the plan if other specified contracts apply.

Because the bill would add a requirement to the act, a violation of which is a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1375.7 of the Health and Safety Code is amended to read:

1375.7. (a) This section shall be known and may be cited as the Health Care Providers' Bill of Rights.

(b) No contract issued, amended, or renewed on or after January 1, 2003, between a plan and a health care provider for the provision of health care services to a plan enrollee or subscriber shall contain any of the following terms:

(1) (A) Authority for the plan to change a material term of the contract, unless the change has first been negotiated and agreed to by the provider and the plan or the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. If a change is made by amending a manual, policy, or procedure document referenced in the contract, the plan shall provide 45 business days' notice to the provider, and the provider has the right to negotiate and agree to the change. If the plan and the provider cannot agree to the change to a manual, policy, or procedure document, the provider has the right to terminate the contract prior to the implementation of the change. In any event, the plan shall provide at least 45 business days' notice of its intent to change a material term, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization require a shorter timeframe for compliance. However, if the parties mutually agree, the 45 business day notice requirement may be waived. Nothing in this subparagraph limits the ability of the parties to mutually agree to the proposed change at any time after the provider has received notice of the proposed change.

(B) If a contract between a provider and a plan provides benefits to enrollees or subscribers through a preferred provider arrangement, the contract may contain provisions permitting a material change to the contract by the plan if the plan provides at least 45 business days' notice to the provider of the change and the

provider has the right to terminate the contract prior to the implementation of the change.

(2) A provision that requires a health care provider to accept additional patients beyond the contracted number or in the absence of a number if, in the reasonable professional judgment of the provider, accepting additional patients would endanger patients' access to, or continuity of, care.

(3) A requirement to comply with quality improvement or utilization management programs or procedures of a plan, unless the requirement is fully disclosed to the health care provider at least 15 business days prior to the provider executing the contract. However, the plan may make a change to the quality improvement or utilization management programs or procedures at any time if the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. A change to the quality improvement or utilization management programs or procedures shall be made pursuant to paragraph (1).

(4) A provision that waives or conflicts with any provision of this chapter. A provision in the contract that allows the plan to provide professional liability or other coverage or to assume *the* cost of defending the provider in an action relating to professional liability or other action is not in conflict with, or in violation of, this chapter.

(5) A requirement to permit access to patient information in violation of federal or state laws concerning the confidentiality of patient information.

(c) *No contract issued, amended, or renewed on or after January 1, 2004, between a plan and a health care provider for the provision of health care services to a plan enrollee or subscriber shall require the contract to apply to patients other than those enrolled directly with the plan if the provisions of another contract would apply to the health care provider, unless the other contract terms do not vary from the underlying contract, or unless the other contract terms have otherwise been first negotiated and agreed to by the plan and the provider.*

(d) Any contract provision that violates subdivision (b) *or (c)* shall be void, unlawful, and unenforceable.

~~(d)~~

(e) The department shall compile the information submitted by plans pursuant to subdivision (h) of Section 1367 ~~of the Health and Safety Code~~ into a report and submit the report to the Governor and the Legislature by March 15 of each calendar year.

~~(e)~~

(f) Nothing in this section shall be construed or applied as setting the rate of payment to be included in contracts between plans and health care providers.

~~(f)~~

(g) For purposes of this section the following definitions apply:

(1) ''Health care provider'' means any professional person, medical group, independent practice association, organization, health facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

(2) ''Material'' means a provision in a contract to which a reasonable person would attach importance in determining the action to be taken upon the provision.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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